MONTANA
Department of Public Health & Human Services

Billing Basics

MONTANA
Department of Public Health & Human Services

Verifying Eligibility:

Is this person eligible?
How will I know?

1. Online, through the Montana Access to Health Web Portal
2. Automated Voice Response System (AVRS)
3. Fax back, 1-800-714-0075
4. Medifax Swipe Card Technology
5. Call Provider Relations, 1-800-624-3958

MONTANA
Department of Public Health & Human Services

Montana Access to Health Web Portal

- https://mtaccesstohealth.acs-shc.com
- Created by ACS in conjunction with DPHHS
- Montana Health Care Programs related information

MONTANA
Department of Public Health & Human Services

Montana Access to Health Web Portal

- Active providers
- Appropriate forms available from the website: www.mtmedicaid.org
- Secure website
- Batch submission for eligibility

MONTANA
Department of Public Health & Human Services

Automated Voice Response Facts

- 1-800-714-0060
- Verbal verification
- Press 3 for eligibility information
- Access one client at a time
  - multiple clients within phone call
- Free to providers

MONTANA
Department of Public Health & Human Services

FAXBACK Facts

- 1-800-714-0075
- Response within minutes
- Paper verification

Using Medifax Services

- Swipe technology – magnetic stripe reader to verify eligibility
  - Available 24/7
  - Paper documentation of eligibility and associated information
  - Batch capability useful for providers with large caseloads
  - Charges associated with use include transaction fees and monthly fees

Provider Relations

- Contacting Provider Relations
  - 1-800-624-3958 or 406-442-1837
  - Hours 8 a.m. until 5 p.m. Mountain Time
  - Monday through Friday

MONTANA
Department of Public Health & Human Services

Client ID

- Multiple Billable Numbers
  - Client Original ID
  - Client Current ID
  - Client Member ID

- Recommend Using:
  - Client Member ID
    - Also referred to as Card Number

Do not bill client member ID with two zeros in front

- Determine:
  - If client has a Passport provider
  - If client has TPL
  - If client has full or basic coverage
  - Other types of coverage information
    - QMB
    - SLMB
    - Medicare
    - HMK
    - HMK Plus
    - PRTF

MONTANA
Department of Public Health & Human Services

Checking Coverage of Codes

- Fee Schedule
  - Can be found at www.mtmedicaid.org
  - Resources by Provider Type
  - What you will see
    - Definitions
    - Code Description
    - Effective Date
    - Method of fee calculation
    - Allowed Amounts
    - Global days for surgical codes

Checking Coverage of Codes cont.

- Prior Authorization
- Multiple surgery rules apply
- Bilateral Rules Apply
- Assistant
- Co Surgeon
- Team
- Policy Adjustor

MONTANA
Department of Public Health & Human Services

Claims Basics including Electronic Claims

Claim Submission

- Billing agent
- Clearing house
- Electronically
  - billing software, direct or WINASAP2003
- Paper

Complete Instructions and Information

- Available at:
  - CMS 1500: www.nucc.org
  - UB-04: www.nubc.org
  - Both: www.cms.hhs.gov

Includes field definitions and valid data for all fields

MONTANA
Department of Public Health & Human Services

1500 Claim Form
Step by Step Instructions

MONTANA
Department of Public Health & Human Services

UB-04 Claim Form
Step by Step Instructions

MONTANA
Department of Public Health & Human Services

Electronic Claims:

Determining Acceptance &

Dealing with Rejection

Electronic Billing Process Overview

- Upload electronic claims (batch)
- Claim screened on HIPAA level
- Claim screened for Montana Specific edits
- Accepted or Rejected

Acronyms & Lingo

- 997
  - 999 beginning January 1, 2012
- 824
- 824PP
- Rejection vs. Denial

HIPAA Based Screening

- 997
  - Functional Acknowledgement
    - 999
      - Functional Acknowledgement beginning January 1, 2012
- Required HIPAA info
- Examples

Montana Specific Edits

- 824s
  - Claim level pertinent information needed
  - Specific for Montana
  - Examples

Montana Specific Edits

- 824 Pre-Processor (824PP)
  - NPI/Taxonomy specific edit
    - NPI
    - Taxonomy
    - Zip + 4
    - CSCT Team number
    - Others
  - NPI/Taxonomy submitted not on file

Rejected vs. Denied

- Rejected claims
  - Do not make it in to process
  - Will not show on remittance advice
  - Can be resubmitted once corrected

- Denied claims
  - Are accepted electronic claims
  - Will show on your remittance advice
  - Can be resubmitted once corrected

Getting Notified of Rejected Claims

- Response depends on submission method
  - WINASAP2003
  - Billing agent
  - Web Portal
  - Clearinghouse
  - Direct Submission

MONTANA
Department of Public Health & Human Services

Interpreting Rejected Claims

- Implementation Guides
  - 5010 X12 Technical Report (TR3) Documents
- Loops and segments
- Provider Relations EDI Support
  - **(800) 987-6719**

MONTANA
Department of Public Health & Human Services

Dealing with Rejected Claims

- Claims reject for lack of information and/or lack of valid information
- My claim rejected now what?
  - Verify claim for prudent information
    - Client ID
    - NPI / Taxonomy entered correct
    - Zip code
    - CSCT Teams number
    - Check qualifiers

Common Questions

- Why can't I see my ESOR! on the web?
- Why did I receive an EFT but no 835?
- Why am I getting payments for a practitioner that I shouldn't?

Common Questions

- How will I know that my enrollment is complete?
- How long should I wait before contacting ACS if I haven't received my letter?

Common Questions

- Do I bill with my NPI / Taxonomy if I am considered an atypical provider?

- What happens if I bill a different rendering than pay-to and I am not required to?

Special Forms:

Adjustments
Blanket Denials
Paperwork Attachments
And
Many, many more. . .

Adjustment Form

- Complete all required sections
- Make sure the information is clear
- Double check that your adjustments are correct
- Do not adjust a denied claim

Updated 03/2011

Montana Health Care Programs

Medicaid • Mental Health Services Plan • Healthy Montana Kids
Individual Adjustment Request

Instructions:
This form is for providers to correct a claim which has been **paid** at an incorrect amount or was **paid** with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete **only** the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information for Providers* manual, or call (800) 624-3958 (Montana and out-of-state providers) or (406) 442-1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name & Address

_____
Name

_____
Street or P.O. Box

_____
City State ZIP

2. Client Name

_____

3. Internal Control Number (ICN)

_____

4. NPI/API

_____

5. Client ID Number

_____

6. Date of Payment _____

7. Amount of Payment $_____

B. Complete only the items which need to be corrected.

	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed – TPL or Medicare paid)			
8. Other/Remarks (Be specific.)			

Signature: _____ Date: _____

When the form is complete, attach a copy of the RA and a copy of the corrected claim.

MONTANA
Department of Public Health & Human Services

Mail to: ACS
P.O. Box 8000
Helena, MT 59604

ACS
A xerox Company

Blanket Denial

- Complete all lines on the form
- Send matching EOB and R&R codes
- Good for 2 years
- Be sure to indicate the blanket denial code on the claim form.

REQUEST FOR BLANKET DENIAL LETTER
ACS – State of Montana Medicaid

Effective Date Requested _____ Provider / NPI _____

Client Name _____

Medicaid ID Number _____

Name of Insurance Company on File _____

Procedure Codes Requested

1. _____
2. _____
3. _____
4. _____
5. _____

Requesting Agency _____

Fax Number _____

Contact Person _____

Contact Phone Number _____

Number of Pages that Follow Request _____

Please fax all requests to (406) 442-0357.

Request must include an EOB stating the services are not covered.

MONTANA
Department of Public Health & Human Services

Paperwork Attachment

- Complete each line of the form
- Indicate paperwork attachment on electronic claims
- Client ID must be the same on paperwork attachment and claim
- Fax to 406-442-4402

OR

- Mail to:

ACS
P.O. BOX 8000
Helena, MT 59604

MONTANA
Department of Public Health & Human Services

ACS
A xerox Company

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of Service: _____

Billing NPI/API: _____

Client ID Number: _____

Type of Attachment: _____

Instructions:
This form is used as a cover sheet for attachments to electronic and paper Montana Health Care Programs (Medicaid; Mental Health Services Plan; Healthy Montana Kids; Indian Health Services Program) claims sent to ACS.

The *Paperwork Attachment Control Number* must be the same number as the *attachment control number* on the corresponding electronic claim. This number should consist of the provider's NPI/API, the client's ID number and the date of service (mmddyyyy), each separated by a dash (NPI: 9999999999-99999999-99999999/Atypical Provider ID: 9999999-99999999-99999999).

This form may be copied or downloaded from the Provider website (http://medicaidprovider.hhs.mt.gov/). If you have questions about which paper attachments are necessary for a claim to process, please call ACS Provider Relations at (406) 442-1837 or (800) 624-3958.

Completed forms can be mailed or faxed to:

ACS
P.O. Box 8000
Helena, MT 59604
Fax: 1-406-442-4402

Address Change Request

- Enter the NPI number to be updated
  - If the NPI has multiple enrollments note if all enrollments on file should be updated
- Enter the new address
- Indicate the type of address
- Physical address change requires a W-9
- IMPORTANT- Individual practitioners must approve any change done to their information with their signature

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604
(406) 442-1837 (Local)
1-800-624-3958 (In- and Out-of-State)
(406) 442-4402 (Fax)

ACS
A xerox Company

Address Correction Form

Physical address change requires a completed W-9.

Provider Number _____

Passport Number
(if applicable) _____

Address 1 _____

_____

_____

☐ Physical Address ☐ Pay-To Address ☐ Correspondence

Address 2 _____

_____

_____

☐ Physical Address ☐ Pay-To Address ☐ Correspondence

Phone Number _____

Fax Number _____

Authorized Signature _____ Date _____

W-9

- Required when changing or updating a physical address
- Physical address must correspond with the address change request form
- Required for enrollment and must match information submitted to IRS

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ► _____
☐ Other (see instructions) ►

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ► **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

Sterilization Form

- The client must be 21 or older when signing the form
- Person obtaining consent must sign, date and provide business address
- Provider must sign and date on or after the procedure
- Date of surgery must be at least 30 days after the client signature.

DPHHS-MA-38
(Rev. 8/98)

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
INFORMED CONSENT TO STERILIZATION

Medicaid Approved

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. When I first asked for
(Doctor or Clinic)
the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care to treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected those alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on _____
(month) (day) (year)

I, _____, hereby consent of my own free will to be sterilized by _____
(Doctor)
by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health & Human Services or Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____
(Signature) **(Date)**

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

- ☐ American Indian or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
(Interpreter) **(Date)**

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed
(name of individual)
the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is as least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____
(Signature of person obtaining consent) **(date)**

_____
(Facility)

_____
(Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon
_____
(Name of person being sterilized)
on _____
(date of sterilization operation)
I explained to him/her the nature of the sterilization operation _____, the fact that it is
(specify type of operation)
intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At lease thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
- ☐ Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery:

(describe circumstances): _____

_____

_____
(Physician) **(Date)**

DISTRIBUTION: 1 - patient; 1 - provider (physician, hospital, etc.); 1 - fiscal agent with claim

Hysterectomy Form

- Section A- the client must sign prior to the procedure
- Section B- provider to indicate cause of prior sterility
- Section C- provider to indicate cause of life threatening emergency

DPHHS-MA-039
(Rev. 9/98)

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

MEDICAID HYSTERECTOMY ACKNOWLEDGMENT

A. RECIPIENT ACKNOWLEDGMENT STATEMENT

I certify that prior to the surgery (hysterectomy), I received both orally and in writing information which explained that I would become permanently sterile and that I would be incapable of reproducing children after the surgery is completed.

Signature of Recipient: _____ Date: _____

PHYSICIAN ACKNOWLEDGMENT STATEMENT

I certify that prior to performing the surgery, I advised _____ *(Name of Recipient)* both orally and in writing that the surgical procedure known as a hysterectomy would render her permanently sterile and that she would be incapable of reproducing children after the surgical procedure is completed. I also certify that this procedure is being done primarily for medical reasons other than sterilization.

Signature of Physician: _____ Date: _____

SIGNATURE OF INTERPRETER (If Required)

Signature of Interpreter: _____ Date: _____

B. STATEMENT OF PRIOR STERILITY

I certify that _____ *(Name of Recipient)* was already sterile and unable to bear children at the time the hysterectomy or other procedure capable of causing sterility was performed. The cause of this recipient's sterility was: _____

_____

_____

Signature of Physician: _____ Date: _____

C. STATEMENT OF LIFE THREATENING EMERGENCY

I certify that the hysterectomy or other sterility causing procedure performed on _____ *(Name of Recipient)* was completed under a life threatening emergency situation in which prior acknowledgment was not possible. The nature of the emergency was _____

_____

_____

Signature of Physician: _____ Date: _____

This form may also be used as a substitute for the sterilization consent form for sterilization procedures where the patient is already sterile and for sterilization procedures (i.e., salpingo-oophorectomy, orchiectomy) done only for medical reasons. With these cases, replace "hysterectomy" with the appropriate procedure name.

MONTANA
Department of Public Health & Human Services

Abortion Form

Provider to complete one section:

Clearly Circle Appropriate Section

- Section I- to be completed by the provider when the service is necessary to save the patient's life
- Section II- to be completed by provider and client certifying the condition resulted from rape or incest
- Section III- to be completed by provider issuing a statement of medical necessity

MA-037
(REV 08/98)

MEDICAID RECIPIENT/PHYSICIAN ABORTION CERTIFICATION

MEDICAID CLAIMS FOR ABORTION SERVICES WILL NOT BE PAID UNLESS THIS FORM IS COMPLETED IN FULL AND A COPY IS ATTACHED TO THE MEDICAID CLAIM FORM.

Recipient Name:_____ Provider Name: _____

Part I, II or III must be completed and the physician completing the procedure must sign below.

I. IF THE ABORTION IS NECESSARY TO SAVE THE RECIPIENT'S LIFE, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

In my professional opinion, recipient suffers from a physical disorder, physical injury or physical illness (or life-endangering physicial condition caused by or arising from the pregnancy itself) that would place the recipient in danger of death unless an abortion is performed.

(attach additional sheets as necessary)

II. IF THE PREGNANCY RESULTED FROM RAPE OR INCEST, THE FOLLOWING MUST BE COMPLETED BY THE RECIPIENT AND PHYSICIAN:

RECIPIENT CERTIFICATION: I Hereby certify that my current pregnancy resulted from an act of rape or incest.

PHYSICIAN CERTIFICATION: If the pregnancy resulted from rape or incest, the physician must mark one of the following and sign below:

____ a. The recipient has stated to me that she has reported the rape or incest to a law enforcement or protective services agency having jurisdiction in the matter or, if the patient is a child enrolled in a school, to a school counselor; or

____ b. Based upon my professional judgement, the recipient was and is unable for physical or psychological reasons to report the act of rape or incest.

III. IF THE ABORTION IS MEDICALLY NECESSARY BUT THE RECIPIENT'S LIFE IS NOT IN DANGER, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

In my professional opinion, an abortion is medically necessary for the following reasons:

(attach additional sheets as necessary)

PHYSICIAN SIGNATURE: _____ **DATE:** _____

THE INFORMATION CONTAINED IN THIS FORM IS CONFIDENTIAL. THIS INFORMATION IS PROVIDED FOR PURPOSES RELATED TO ADMINISTRATION OF THE MEDICAID PROGRAM AND MAY NOT BE RELEASED FOR ANY OTHER PURPOSE WITHOUT THE WRITTEN CONSENT OF THE RECIPIENT.

MONTANA
Department of Public Health & Human Services

Provider File Updates

My Provider Works in Multiple Locations

- Verify the provider NPI is enrolled with Montana Health Care Programs
- Billing provider should be the clinic or facility
- Do not update his personal information

A Provider Changed Facility
Now What?

- Verify the providers NPI is enrolled with Montana Health Care Programs
  - If not enroll the NPI with Montana Health Care Programs at www.mtmedicaid.org
  - Provider file updates should only be required if provider moving to a private practice.

MONTANA
Department of Public Health & Human Services

Address Change

- Three types of address changes
  - Physical
  - Pay-to
  - Correspondence
- Each requires an address correction form
  - Or a letter which identifies an address is to be changed
- An updated W-9 must be attached to the Address Change Form ONLY if a physical address is being updated

NOTE: Individual practitioners must approve any change done to their information with their signature

Contact Changes

- Mail or fax a letter to ACS requesting a phone number change
  - Double check that the fax number is correct
- Update or confirm email address on file

MONTANA
Department of Public Health & Human Services

Bank Information

- Mail or fax a Direct Deposit Form with the updated information
- Banker signature is required
- Effective Date of Change

CLIA Updates

- Required for all providers who provide laboratory services
- Mail or fax the current CLIA
- Highest level of CLIA will put on the provider file
  - All other CLIAs received will also be kept in the document repository
- Verification letter not sufficient

Things to stay on top of…

Fee Schedule

- Important to keep updated
- Can be found under Resources by Provider Type
- Be sure to use the fee schedule that corresponds with the dates of service

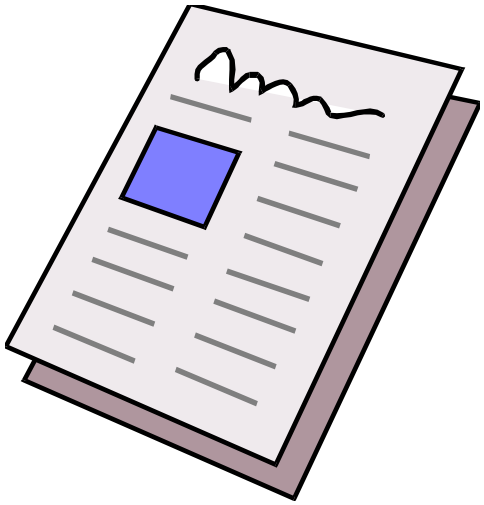
E!SOR

- Send a request to have the provider's NPI linked to the submitter number

- If you no longer want to receive paper remits you can request the change by:
  - Email mtprhelpdesk
  - Fax 406-442-4402
  - Mail to

    ACS
    Attn: Provider Relations
    PO BOX 4936
    Helena, MT 59604

Claim Jumper



- Monthly newsletter
- Access all issues online
- Provides news, updates, and tips regarding Montana Health Care Programs

MONTANA
Department of Public Health & Human Services

What's New

- Check out www.mtmedicaid.org for weekly postings

- The best way to stay current is to visit the site with all the information

Questions?